STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155510	A. BUILDING 01 B. WING	09/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTURY VILLA HEALTH CARE	705 NORTH MERIDIAN STREET GREENTOWN, IN46936

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000				
	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/12/11 Facility Number: 000549 Provider Number: 155510 AIM Number: 100267470 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Century Villa Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The original building consisting of everything except the 100 hall and the attached workshop was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	corridors and spaces open to the corridors. The facility has a capacity of 84 and had a census of 68 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/16/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0017 SS=E	Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 2 open use areas were separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1, Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for	K0017	1) A smoke detector will be installed in the waiting room next to the beauty shop.2) No residents affected.3-4) This is a one-time occurrence and the deficiency was corrected. No other areas are affected.	10/12/2011

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	patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect 22 resident on 400 hall as well as visitors and staff. Findings include: Based on observation on 09/12/11 at 1:15 p.m. with the Maintenance Supervisor, Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the waiting room next to the beauty shop was open to the corridor and did not allow direct supervision by facility staff and was not protected with a smoke detector. Based on interview on 09/12/11 at 1:20 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned room			

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	was open to the corridor without supervision from the nurse's station and was not protected by automatic smoke detection. 3.1-19(b)			
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 4 smoke barrier walls observed were protected to maintain the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.2 requires smoke barriers be continuous from an outside wall to an outside wall, from a floor to a floor, from a smoke barrier to a smoke barrier or some combination thereof. Such barriers shall be continuous through all concealed spaces such as those found above a ceiling, including interstitial spaces. This deficient practice could affect 22 residents on 400 hall as well as visitors and staff if	K0025	1) The unprotected opening in the wall will be repaired with fire rated materials.2) No other residents affected.3) All openings on fire wall will be firestopped.4) Maintenance Supervisor will be notified/aware of any opening in fire wall & opening will be repaired with fire-rated materials.	10/12/2011

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	smoke from a fire were to infiltrate the protective barrier wall. Findings include: Based on observations on 09/12/11 between 2:30 p.m. and 3:01 p.m. with the Maintenance Supervisor, there was a seven inch by seven inch opening on the east side of the 400 hall smoke wall which was not firestopped. Based on interview on 09/12/11 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier wall had an unprotected opening which was not sealed with a fire rated material. 3.1-19(b)			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 12 doors	K0029	1) A self-closing device will be installed on the corridor door.2) No residents affected.3) All doors	10/12/2011

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	leading to hazardous areas such as rooms over fifty square feet in size with combustible items were provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 22 residents on 400 hall as well as visitors and staff. Findings include: Based on observation on 09/12/11 at 2:00 p.m. with the Maintenance Supervisor, the Wheelchair storage room on 400 hall was greater than fifty square feet in size and had 22 cardboard boxes stored inside without a self closing device on the corridor door. Based on interview on 09/12/11 at 2:02 p.m. with the Maintenance Supervisor, it was confirmed the aforementioned door leading into the storage room on 400 hall was not equipped with a self closing device on the corridor door. 3.1-19(b)		requiring self-closing devices have then in place.4) No doors requiring self-closing devices will have them removed.	

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K0051 SS=E	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 Based on observation and interview, the facility failed to ensure 3 of 5 smoke detectors on 300 hall and 2 of 18 smoke detectors on 400 hall were installed in a location which would allow the smoke detector to function to its fullest capability. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 32 residents on 300 hall and 22 residents on 400 as well as visitors and staff. Findings include: Based on observations on 09/12/11 during	K0051	1) All smoke heads will be moved away from air flow.2) No residents affected.3) Maintenance Supervisor will monitor all smokeheads and insure adequate separation from air supply & return.4) No smokehead will be installed without the Maintenance Supervisor's approval and supervision.	10/12/2011

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	the tour between 12:45 p.m. and 1:20 p.m. with the Maintenance Supervisor, there following smoke detectors were within three feet of an air diffuser: a. One smoke detector in the Storage room adjacent to the Chapel on 300 hall was installed within one inch of an air supply vent. b. Two smoke detectors in the Chapel, one on the east portion of the ceiling above the exit sign and one on the center west portion of the ceiling were two feet and one foot respectively from an air supply vent. c. One smoke detector next to the cafe on 400 hall was two feet from an air supply vent and one smoke detector in the beauty shop on 400 hall was one foot from an air supply vent. Based on interview on 09/12/11 concurrent with each observation, it was acknowledged by the Maintenance Supervisor the aforementioned smoke detectors were installed within three feet from an air supply duct in the ceiling which would interfere with the smoke detector's ability to detect smoke to its fullest capability. 3.1-19(b)			

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K0056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to provide a minimum of 6 feet spacing between 2 of 2 sprinkler heads in the Conference room on 400 hall. NFPA 13, 1999 Edition, at 5-6.3.4 requires sprinklers to be spaced not less than 6 feet on center. This deficient practice could affect 22 residents on west hall as well as visitors and staff. Findings include: Based on observation on 09/12/11 at 2:30 p.m. with the Maintenance Supervisor, the sprinkler head above the entrance door inside the Conference room on 400 hall was separated from the other sprinkler head by four feet. Based on interview on 09/12/11 at 2:32 p.m. with the Maintenance Supervisor, it was acknowledged the spacing between the two sprinkler heads was less than six feet	K0056	1) One sprinkler head will be removed.2) No residents were affected.3) Maintenance Supervisor will monitor all sprinkler installations and ensure adequate separation.4) No sprinkler will be installed without the Maintenance Supervisor's approval and supervision.	10/12/2011

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	apart. 3.1-19(b)			
K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to replace 2 of 24 sprinkler heads observed on 300 hall which had paint on the fusible link. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect the 32 residents on 300 hall as well as staff and visitors. Findings include: Based on observations on 09/12/11 during the tour between 11:15 a.m. to 11:30 a.m., the sprinkler head located in the Med room and adjacent storage room had paint on the fusible link. Based on interview on 09/12/11 concurrent with each observation with the Maintenance Supervisor, it was confirmed the sprinkler heads located in the aforementioned rooms had paint on the fusible link.	K0062	1) All traces of water-soluble drywall compound were removed from the sprinkler heads with water.2) No residents were affected.3) This was a one-time incident which occurred during remodeling.4) All remodeling affecting ceilings will be monitored by the Maintenance Supervisor to ensure all sprinkler heads are unaffected.	10/12/2011

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	3.1-19(b)			
K0064 SS=E	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient	K0064	1, 3) The fire extinguisher in question will be moved to a conspicuous area and a placard will be mounted next to it.2) No residents were affected.4) Maintenance staff will monitor location of extinguisher and placard on a monthly basis during preventative maintenance. Inservice training re: proper use of the K class fire extinguisher in conjunction with the hood extinguishing system will be completed by 10/12/11.	10/12/2011

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	practice could affect 22 residents on 400 hall as well as visitors and staff. Findings include: Based on observation on 09/12/11 at 2:08 p.m. with the Maintenance Supervisor, there was a K class portable extinguisher partially hidden behind a metal food cart next to the kitchen entrance and it lacked a placard. Based on interview on 09/12/11 at 2:10 p.m. with the Maintenance Supervisor, it was acknowledged the K class extinguisher was not conspicuously located and lacked a placard. 3.1-19(b)			
K0067 SS=F	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on record review and interview, the facility failed to ensure 20 of 20 dampers in ventilating system's ductwork were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. NFPA 90A,	K0067	1) All dampers will be inspected to verify they are in good working order in accordance with NFPA 90A.2) No residents affected.3, 4) Dampers will be placed on a preventive maintenance schedule to be	10/12/2011

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	1999 Edition, 3.4.7, maintenance requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents including visitors and staff. Findings include: Based on Fire Safety record review on 09/12/11 at 3:45 p.m. with the Maintenance Supervisor, documentation was not available to indicate the dampers had ever been inspected. Based on an interview on 09/12/11 at 3:47 p.m. with the Maintenance Supervisor, it was acknowledged the facility does not have any documentation to verify the twenty fire dampers have ever had a four year maintenance inspection. 3.1-19(b)		inspected, and repaired if needed, at least every four years.	

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K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer was occurring was separated within a one hour fire barrier enclosure. This deficient practice could affect 22 residents on 400 hall as well as visitors and staff near the oxygen storage room. Findings include: Based on observation on 09/12/11 at 1:50 p.m. with the Maintenance Supervisor, the fire rating tag found on the corridor door to the oxygen transfer room on 400 hall indicated it was a twenty minute fire rated door. Based on interview on 09/12/11 at 1:55 with the Maintenance Supervisor, it was acknowledged oxygen transfer occurs in the oxygen storage room and the door to the oxygen storage room was a twenty	K0143	1) A one-hour fire rated door will be installed and a sign posted on the door will indicate "oxygen transfer occurring".2) No residents affected.3) The door is a one-time incident.4) A sign will be permanently fastened to door stating "oxygen transfer occurring".	10/12/2011

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	minute fire rated door which would not maintain a one hour fire rated enclosure. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms, where oxygen transfer occurs had a sign posted indicating oxygen transferring was occurring in the oxygen storage room. This deficient practice could affect 22 residents on 400 hall as well as visitors and staff near the oxygen storage room. Findings include: Based on observation on 09/12/11 at 1:45 p.m. with the Maintenance Supervisor, the oxygen transfer room on 400 hall where liquid oxygen containers were stored was used to transfill oxygen and lacked a sign to post on or near the oxygen storage room door indicating the transfer of oxygen was being conducted at this site. Based on interview on 09/12/11 at 1:47 p.m. with the Maintenance Supervisor present, it was acknowledged by the charge nurse that oxygen transfers takes place in the oxygen storage room but a sign to indicate such conduct was not available anywhere in the facility. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155510	A. BUILDING 01 B. WING	09/12/2011

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K0000				
	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/12/11 Facility Number: 000549 Provider Number: 155510 AIM Number: 100267470 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Century Villa Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code), and 410 IAC 16.2. The 100 hall and the attached workshop were were surveyed with Chapter 18, New Health Care Occupancies. This one story facility was determined to	K0000		

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	be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 84 and had a census of 68 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0039 SS=E	Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited care facilities and psychiatric hospitals, width of aisles or corridors is at least 6 feet. 18.2.3.3, 18.2.3.4 Based on observation and interview, the facility failed to ensure the width of corridors was at least eight feet wide for 1 of 1 corridors on Service hall. This deficient practice could affect 17 residents on 100 hall as well as visitors and staff using 100 hall exit during an emergency evacuation. Findings include: Based on observation on 09/12/11 at 2:15	K0039	1) Hallway will be clear and unobstructed so that 8' of clearance is available.2) No residents affected.3) No storage cabinets will be stored in hallway.4) Maintenance Supervisor & staff will monitor hallways to assure corridors are not blocked.	10/12/2011

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	p.m. with the Maintenance Supervisor, there were seven wooden storage cabinets against the south corridor wall, two feet deep which limited the corridor width to six feet. Based on interview on 09/12/11 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the wooden storage cabinets occupied two feet of space in the Service corridor and limited its available width for evacuation to six feet. 3.1-19(b)			
K0067 SS=F	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A Based on record review and interview, the facility failed to ensure 20 of 20 dampers in ventilating systems ductwork were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. NFPA 90A, 1999 Edition, 3.4.7, Maintenance requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents including visitors and staff.	K0067	1) All dampers will be inspected to verify they are in good working order in accordance with NFPA 90A.2) No residents affected.3, 4) Dampers will be placed on a preventive maintenance schedule to be inspected, and repaired if needed, at least every four years.	10/12/2011

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	Findings include: Based on Fire Safety record review on 09/12/11 at 3:45 p.m. with the Maintenance Supervisor, documentation was not available to indicate the dampers had ever been inspected. Based on an interview on 09/12/11 at 3:47 p.m. with the Maintenance Supervisor, it was acknowledged the facility does not have any documentation to verify the twenty fire dampers have ever had a four year maintenance inspection. 3.1-19(b)			